Research Paper

Quality of Life of Older Adults Supported by a Government Welfare Foundation: A Qualitative Phenomenological Study in Yazd City, Iran

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ABSTRACT

Background and Purpose: As the global population ages, the quality of life (QoL) of older adults has become a major public health and social policy concern, particularly among socioeconomically vulnerable groups supported by governmental welfare institutions. In Iran, limited evidence exists on how older adults perceive their QoL in the context of state-provided welfare services. This study aimed to explore the lived experiences of older adults supported by a government welfare foundation regarding their QoL in Yazd City, Iran.

Materials and Methods: A qualitative phenomenological design was employed. Participants were selected through purposive sampling, and in-depth semi-structured interviews were conducted with 31 older adults receiving support from a government welfare foundation in Yazd City. Data were analyzed using Zhang's approach.

Results: The analysis generated 674 initial codes, which were grouped into 17 subcategories and further condensed into seven main categories. The key dimensions of QoL included life satisfaction, health, economic security, environmental conditions, access to the Foundation, perceived services provided, and unmet needs and expectations.

Conclusion: The findings indicate that while welfare support alleviates material hardship, it alone is insufficient to meaningfully enhance older adults' QoL. Improving well-being requires a shift toward person-centered, integrated models of care that address psychosocial needs, social connectedness, dignity, and financial assistance. For Foundations and policymakers, investing in community-based and preventive social and mental health interventions is essential. Such reorientation can lead to more sustainable and impactful welfare policies amid rapid population aging.

Keywords: Aged, Quality of life (QoL), Qualitative, Phenomenology, Social welfare

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Introduction

Many older adults, particularly those who require assistance with daily activities, face health challenges, such as chronic diseases. The primary goal of these individuals is to maintain or improve their quality of life (QoL) [1]. The World Health Organization Quality of Life (WHOQOL) model conceptualizes QoL as individuals' subjective perceptions of their position in life within the context of the culture and value systems in which they live, and in relation to their goals, expectations, standards, and concerns. This model emphasizes that QoL is a multidimensional and culturally sensitive construct rather than merely an objective assessment of health status [2]. The present study is informed by a multidimensional conceptual framework of QoL in older adults based on the WHOQOL model. QoL is conceptualized as a subjective construct shaped by physical, psychological, social, and economic/environmental domains [3].

The results of a systematic review on QoL among older adults in Iran indicated that 7% reported a high QoL, 50% a moderate QoL, and 42% a low QoL. QoL in this population is influenced by multiple factors, including social support, economic conditions, socioeconomic status, demographic characteristics, physical health status, place of residence, and educational, physical activity, and nutritional interventions [4].

Compared to other age groups, older adults are at a significantly higher risk of financial strain, largely due to declining physical and mental health [5, 6]. Poverty and economic vulnerability are considered key structural determinants of QoL domains, while welfare support provided by institutions is viewed as a contextual factor that may partially buffer the negative effects of poverty on QoL. Individual perceptions and lived experiences mediate the translation of such support into perceived QoL. Lack of access to robust social safety nets, inadequate health insurance coverage, and shortage of social, transportation, and recreational facilities can significantly influence the QoL of older adults [7, 8].

The relationship between age and poverty follows a "U" shaped pattern, with older adults being disproportionately vulnerable to economic hardship and deprivation compared to other age groups [9]. Governments have traditionally played a key role in promoting the welfare of older adults through macro-policies, pension funds, and public-benefit institutions [10].

Iran has over 6 million elderly citizens (60 years and above), with 25% receiving support from the Imam Khomeini Relief Foundation (IKRF). The IKRF, a government organization, was established on March 5, 1979, shortly after the victory of the Islamic Revolution of Iran. Its primary mission was to address the livelihood needs of the country's deprived and underprivileged people [11]. IKRF assists approximately 1.67 million elderly individuals, with 62% of beneficiaries being women and 38% men. Forty percent of those receiving support live in urban areas, while 60% reside in rural settings, with an additional 8,000 nomadic individuals included in this support network [12].

Although several quantitative studies in Iran have examined QoL among older adults, there is limited qualitative evidence on how economically disadvantaged elderly individuals, particularly beneficiaries of welfare institutions, perceive and experience their QoL. Existing research has largely relied on standardized measures and has paid insufficient attention to older adults' subjective meanings, priorities, and experiences of institutional support. This represents a key knowledge gap in understanding QoL among poor older adults in the Iranian context. Therefore, this study asked: How do older adults receiving support from IKRF in Yazd City, Iran, perceive and experience their QoL?

Materials and Methods

Study design

This phenomenological qualitative study was conducted in 2024 to explore the experiences of 31 older adults supported by IKRF regarding QoL. This study adopted a phenomenological qualitative approach grounded in an interpretivist paradigm, viewing reality as socially constructed and meaning as arising from individuals' lived experiences. Phenomenology was chosen over generic qualitative content analysis to capture the essence of older adults' experiences of QoL, rather than simply categorizing textual data. This approach allows a deeper understanding of how vulnerable older adults perceive and interpret their QoL and the support they receive from welfare institutions.

The inclusion criteria for the study were as follows: age >60 years, residing in urban areas, no disorders, such as Alzheimer's disease, blindness, or deafness, and ability to communicate. Elderly people with cognitive impairment were excluded from the study based on their mini-mental state examination (MMSE). A score of 23 or lower indicates cognitive impairment [13]. In total, three elderly people were excluded from the study due to cognitive impairment. In total, 31 older adults participated in this study.

Participants

The study was conducted within the organizational context of the IKRF's local office, which operates under a centralized welfare governance framework. The local office is responsible for identifying eligible beneficiaries, assessing socioeconomic status, and delivering financial and supportive services, including health-related referrals and social assistance. Services are implemented according to national policies while being adapted to local demographic and socioeconomic conditions. This organizational setting provided the structural framework for participant recruitment and service-related data collection. A total of 2,998 elderly people received services from the IKRF in Yazd City's urban areas. Participants were selected using purposive sampling with a maximum variation strategy. The purposive criteria included variation in gender, marital status, living arrangement (living alone vs with family), and duration of receiving IKRF support. This approach was intended to enhance the diversity and richness of perspectives and to allow exploration of both shared and divergent experiences across different social and living contexts. Recruitment was conducted in collaboration with the local IKRF office in Yazd City. Foundation staff first identified potentially eligible participants based on the inclusion criteria and informed them about the study. Individuals were then contacted by the research team, either by phone or in person, to provide further information about the study and to arrange interview appointments. Participation was entirely voluntary, and written informed consent was obtained from all participants prior to data collection. Information was collected through semi-structured interviews with 31 older adults supported by IKRF in Yazd City. A total of 38 older adults supported by the Foundation were initially approached and assessed for eligibility. Of these, four individuals declined to participate, and three were excluded for not meeting the inclusion criteria (primarily cognitive impairment as assessed by the MMSE). Ultimately, 31 participants were interviewed. Recruitment and data collection continued until thematic saturation was achieved.

Data collection

After selecting the samples, the participants were contacted and invited to participate in this study. With permission from the elderly individuals and coordination with their families, while ensuring adherence to health protocols, visits were made to the participants' homes, where face-to-face semi-structured narrative interviews were conducted using an interview guide. In developing the interview questions, we ensured they were open-ended, broad in scope, and aimed at gaining deeper insight into the primary phenomenon under investigation in our research.

The interviews were conducted following the guidelines established by DeJonckheere and Vaughn [14], which include several key steps. These steps included defining the study's purpose and scope, selecting appropriate participants, creating an interview guide, conducting interviews, engaging in memoing and reflective practices, and subsequently analyzing the collected data.

Following DeJonckheere and Vaughn's framework for conducting semi-structured interviews, we operationalized their recommended steps throughout the data collection process. Specifically, an initial interview guide was developed based on the study objectives, the WHOQOL conceptual framework, and a review of relevant literature. The guide was piloted with two older adults who met the inclusion criteria but were not included in the final analysis, thereby allowing us to refine the wording, sequencing, and clarity of the questions. Consistent with an iterative qualitative approach, the interview guide was refined during early stages of data collection. After the first few interviews, the research team reviewed the transcripts and field notes to identify areas where questions were unclear or insufficiently elicited rich descriptions of participants' experiences. Based on this reflexive process, additional probes were added (e.g. prompts to explore emotional responses, perceived adequacy of institutional support, and daily challenges), and some questions were rephrased to better match participants' language and context. While the core domains of the guide remained stable across interviews to ensure comparability, probes and follow-up questions were adapted flexibly in response to emerging themes, allowing deeper exploration of salient issues raised by participants.

Sample interview guide questions are below: "How would you describe your living situation?", "Are you satisfied with your living situation? To what extent, and why?", "What challenges or problems do you face?"

We also considered classic socio-demographic variables (age, gender, educational level, marital status, living arrangement, and insurance) and factors relevant to the specific life contexts of older adults, such as illness, medication use, use of assistive devices, and duration of support received. The duration of each interview session with participants ranged from approximately 45-90 minutes, continuing until data saturation was reached.

Data saturation was determined using thematic saturation, defined as the point at which no new themes or meaningful insights emerged from successive interviews. After approximately 25 interviews, no new conceptual categories were identified, and six additional interviews were conducted to confirm saturation. Saturation was evaluated through ongoing team discussions and concurrent data analysis, consistent with an iterative qualitative approach. All interviews were conducted in Persian (Farsi) to ensure participants' comfort and depth of expression. Selected quotations were translated into English by the first author and reviewed by a second qualitative researcher to ensure accuracy and preserve meaning. Discrepancies were resolved through discussion, and translations were refined to maintain conceptual equivalence rather than literal wording.

Data analysis

The interview discussions were audio-recorded, transcribed, and analyzed using MAXQDA 2018 software. To analyze the interview data, a conventional content analysis was conducted following Zhang's approach [15]. This method involved eight steps: preparing the data, defining semantic units, creating initial codes and categories, testing these codes and categories, coding all interviews, checking code consistency, drawing conclusions from the codes, and reporting the methods and findings.

The recorded data were transcribed after the interviews. The interview text was read multiple times to identify semantic units, from which primary codes were extracted using MAXQDA software. The primary codes were refined by merging similar codes and removing duplicates. A total of 674 primary codes were extracted and subsequently organized into seven themes based on their content.

Trustworthiness

The trustworthiness of the qualitative findings was examined using the criteria of credibility, confirmability, dependability, and transferability [16].

Credibility: Member checking was conducted with (5–7) participants, who were provided with a brief written and/or verbal summary of the preliminary themes. The participants were invited to comment on the accuracy and resonance of the interpretations. Minor clarifications were made to the wording of two themes based on their feedback; no substantive changes to the overall thematic structure were required.

Dependability and confirmability: An audit trail was maintained throughout the study, including documentation of successive versions of the codebook, analytic memos, and reflexive notes on coding and category development. Peer debriefing was conducted through regular meetings with (two qualitative researchers/supervisors), who independently reviewed selected transcripts and coding decisions. Discrepancies and analytic decisions were discussed until consensus was reached, and key decisions were recorded in a decision log within MAXQDA.

Transferability: Maximum variation sampling was used to enhance the transferability of findings by including participants with diverse characteristics, including variations in age (e.g. 60–85 years), gender (men and women), living arrangements (living alone vs. with family), and duration of receiving Foundation support (e.g. less than 2 years to more than 10 years).

Results

The participants' age range was 60-90 years, with a mean age of 69.55± 9.28 years. The majority of the older adults were female (n=20, 64.5%) and married (n=11, 54.8%) (Table 1).

This study's analysis yielded high-quality findings, leading to the extraction of 674 primary codes, which were categorized into 17 sub-themes and seven main themes (Table 2).

The main categories and subcategories were presented, along with direct quotes from the participants.

Life satisfaction

The analysis revealed that life satisfaction is a critical dimension of QoL in older adults, encompassing the following subcategories:

a. Satisfaction

b. Non-satisfaction

a. Satisfaction: Satisfaction often stemmed from positive relationships, grandchildren, visiting relatives, living with a spouse, satisfaction with the spouse's physical condition, and satisfaction with the spouse's independence in activities of daily living. A 60-year-old woman stated, "My husband is independent. It is great that my husband is not disabled (participant 1, 60 years old, housewife)."

Table 1. Frequency distribution of demographic characteristics of the participants

Variables		No. (%)
Gender	Male	11(35.5)
	Female	20(64.5)
Marital status	Married	17(54.8)
	Unmarried	14(45.2)
Educational level	Illiterate	19(61.3)
	Literate	12(38.8)
Insurance	Yes	24(77.4)
	No	7(22.6)
Use of assistive devices	Yes	12(38.7)
	No	19(61.3)
Living arrangement	With spouse	14(45.2)
	With children	11(35.4)
	Alone	6(19.4)

Satisfaction with the way children are raised and contentment are the other factors. A 64-year-old participant expressed gratitude, saying, "God has given me everything, and I have never had to rely on others (participant 2, 64 years old, retired)."

Other factors included financial support from relatives, employment, independence in daily tasks, privacy at home, and assistance from children. A 90-year-old man said, "My children visit me every day; they ask how I am. Just being here makes me feel less lonely (participant 16, 90 years old, working but not earning an income)."

Satisfaction with the amount of work and activity performed has also been previously expressed as an internal factor. In this regard, a 62-year-old man stated, "Now that I can no longer work, but thank God, I worked and earned an income as long as I could and was able to (participant 15, 62 years old, retired)."

b. Non-satisfaction: Both external and internal factors can cause dissatisfaction with life. External factors included living with children, the inability to walk, and dependence on children. A 60-year-old woman said, "My son divorced his wife because of me. His wife said, 'Either your mother or me.' My son also said, 'My mother. If I am not with him, who will be? That is why he divorced his wife (participant 12, 60 years old, housewife)."

Internal factors included the inability to pay rent, provide necessities of life, purchase medicine, cover dowry and marriage expenses for children, lack of attention and assistance from responsible organizations in providing necessities of life, lack of income, and lack of financial independence. A 64-year-old woman remarked, "I cannot afford rent, and my son helps, but his financial situation is also poor (participant 6, 60 years old, housewife)".

In addition to external factors, contracting various diseases, the death of loved ones, worrying about the future, working too much in the past, and the emergence of numerous physical problems in present life have been internal factors for dissatisfaction with life in the elderly. For example, an 88-year-old woman expressed the reason for dissatisfaction with her life situation as follows: "I am not satisfied with my life. One of my daughters has cancer and her leg was amputated because of cancer. Another daughter is separated from her husband and lives here with her children. My daughter has also rented this house (participant 8, 88 years old, housewife)."

Health

One of the most important dimensions of QoL is health across the physical, mental, social, and spiritual domains [17].

Table 2. Main themes and sub-themes from interview

No.	Themes	Sub-themes
1	Life satisfaction	Satisfaction Non-satisfaction
2	Health	Physical health Psychological health Social health
3	Environment	Residential conditions Environmental conditions Aging in place
4	Economic security	Financial circumstances of the elderly Family financial condition Sources of income for the elderly
5	Access to foundation	Access barriers Access facilitators
6	Perceived provided services	Perceived adequacy of services Perceived responsiveness of services
7	Unmet needs and expectations	Financial needs Non-financial needs

a. Physical health: One of the most important issues to consider in old age is the physical health of individuals, which changes with age [18]. Aging-related changes and illnesses or geriatric syndromes, such as falling, fractures, sensory impairments, balance disorders, constipation, physical deterioration, weight loss, prostate hyperplasia, vision and hearing problems, inability to walk, work, and occupation due to physical problems and illness, and joint pain significantly affect physical health. For instance, an 88-year-old participant said, "I fell and fractured my pelvis. Since then, I cannot do much (participant number 5, 88 years old, housewife)".

A 90-year-old man with prostate problems said, "Because my prostate is swollen, I have to go to the bathroom every two hours even if I am asleep (participant 30, 90 years old, retired)."

b. Psychological health: Mental health issues, such as anxiety, depression, and insomnia, are prevalent [19]. A 63-year-old participant shared, "I barely sleep for three hours at night and cannot rest during the day (participant 17, 63 years old, housewife)". Concerns about family finances, loneliness, and dependency were common, as were feelings of shame regarding reliance on aid. An 88-year-old participant said, "I tell neighbors I'm visiting family, not the Aid Committee, because I'm embarrassed (participant 10, 88 years old, housewife)".

c. Social health: As the population ages, it is important to recognize the role of social factors in promoting health. The elderly's interactions with family, community, and social networks significantly impact their QoL. Social engagement, such as family visits and community participation, helps combat loneliness and promotes physical and mental health [20]. This study identified three primary aspects of social health: social participation, social support, and leisure activities. These factors are vital to the overall well-being of the elderly population.

c-1. Social participation and engagement: Social participation is a significant factor in enhancing the QoL of older adults. Common activities include visiting children's

homes, attending mosques, and conversing with others. One participant, a 64-year-old woman, expressed the importance of social interactions: "I spend one to two hours every evening sitting with my neighbor. I feel less lonely when I talk. It has become part of my daily routine" (participant 31, 64 years old, housewife).

A 70-year-old woman shared a similar sentiment, highlighting the importance of connecting with others: "I often go to the shop or sit at the mosque. There, I meet other elderly women like myself, and we chat. It helps me feel connected (participant 21, 70 years old, housewife)".

However, lack of community presence and limited interaction with others can decrease the QoL of the elderly. A 78-year-old woman noted the difficulties she faces: "I cannot go outside by myself. I have to use a cane, and I do not have any friends nearby to accompany me. It makes me feel isolated (participant 24, 78 years old, housewife)".

c-2. Social support: Social support plays a critical role in enabling older adults to thrive and enhance their QoL. Various forms of assistance from family and relatives include travel assistance by children and neighbors to the Foundation or other important locations, financial support, home shopping and household management, food preparation and delivery by children, caregiving support, health-related assistance (doctor's appointments, facilitating medical care, and providing support during visits), and providing household items. These acts of care and support not only meet the practical needs of older adults, but also strengthen their social connections, contributing significantly to their overall well-being and satisfaction. The sense of being cared for by loved ones plays a critical role in improving older adults' QoL.

A 66-year-old woman explained how her family's support gave her a sense of security: "My husband's support gives me a sense of safety. I feel secure knowing he is there for me (participant 18, 66 years old, housewife)".

An 80-year-old woman similarly shared how her daughter's help with food and daily care prevented her from feeling neglected: "My daughter brings me food when I cannot cook. If she did not, I would go hungry (participant 7, 80 years old, housewife)".

Conversely, the absence of family support, financial constraints, and long distances between elderly individuals and their children can lead to feelings of neglect and decreased QoL. A 64-year-old woman expressed concern about the limitations her son faces in providing support: "My son wants to help, but his situation is difficult. He cannot do much for me right now (participant 9, 64 years old, housewife)".

c-3. Leisure and recreation: Leisure activities are important for maintaining mental and physical health during old age. However, some elderly individuals face barriers in participating in recreational activities. A 64-year-old woman shared how her caregiving responsibilities limited her opportunities for recreation: "When my daughter and son-in-law were at work, I could not leave the house. I stay home to care for my grandchildren. i have no time for myself (participant 31, 64 years old, housewife)".

Some elderly individuals, such as a 90-year-old man, feel disengaged from leisure activities due to physical limitations and lack of motivation: "I do not enjoy watching television anymore. It is only the news that I watch occasionally, but even then, it does not feel like fun (participant 30, 90 years old, retired)".

In contrast, others engage in media activities, such as watching TV or listening to the radio as their primary form of entertainment. Many also enjoy meeting family members or neighbors, going to parks, or taking walks. A 71-year-old woman said "I love spending time with my grandchildren. We play games together. They bring joy to my life (participant 3, 71 years old, housewife)".

Environment

Attention to the environment is crucial, as it can significantly impact the QoL [21]. In many societies, particularly in Asia, there have been limited improvements in the physical environment of older adults. The QoL of older individuals can be significantly influenced by how well their environments meet their needs. An environment that supports physical and emotional well-being contributes to greater satisfaction and improved QoL. In this context, the ability of the elderly to live in an environment that aligns with their needs can help them achieve better QoL. In many cases, environmental conditions, especially in aging societies, do not adequately address the challenges faced by the elderly, such as the risk of falls or mobility [22]. Three sub-categories were identified regarding the environment: status of residence, conditions of the residential environment, and aging in place.

a. Status of residence: The status of an elderly person's residence plays a significant role in their well-being and includes whether they live in rental accommodations, their own homes, or with family members. Elderly people's satisfaction with their living situations can significantly affect their overall QoL. Living with children or relatives may provide comfort; however, in some cases, it can lead to dissatisfaction, especially if the elderly feel a lack of independence or personal space. A 76-year-old woman said, "I have lived with my daughter and son-in-law since my husband passed away. This was difficult for me. I feel like a burden on them, and I do not have my own space (participant 20, 67 years old, housewife)".

b. Conditions of the residential environment: The physical condition of the home plays an important role in QoL. Factors, such as the presence of stairs, unsafe flooring, or inadequate space for mobility, can pose significant health risks. A poorly maintained or inaccessible home can reduce QOL by limiting the ability to move freely or access essential resources. An 86-year-old woman shared her struggles with her living conditions: "I cannot leave the house easily because of the stairs. I have to climb two flights of stairs to get out. The home is uncomfortable, and the layout makes it difficult to move around (participant 23, 86 years old, housewife)".

A 63-year-old male expressed similar concerns regarding his home's environment: "There are too many stairs in my house. I cannot go outside without facing several obstacles. The walls were damaged and often cold. Even using the bathroom is a struggle, and it frustrates me every time (participant 4, 63 years old, unemployed)".

c. Aging in place: Aging in place, the concept of elderly individuals living in their own homes and communities as they age, is another key factor in improving QoL. Many elderly people prefer to remain in their homes rather than move to care facilities, as they provide a sense of familiarity and independence. The ability to age in place enhances dignity and contributes to a higher QoL. An 80-year-old woman said about living alone: "Since my husband passed away, I have lived alone. I do not want to live with my children. I prefer to stay in my own home, even if I have to face challenges alone (participant 7, 80 years old, housewife)".

Economic security

Based on the findings of this study, the financial status of the elderly can significantly affect their daily living, health, and well-being. Economic security is a broad concept that includes personal and family finances, as well as income sources. Economic security can be divided into three subcategories:

a. Financial status of an individual elderly person

b. Financial status related to the family of elderly persons

c. Income sources of the elderly population

a. Financial status related to the elderly person: The elderly's personal financial status plays a significant role in their ability to access necessary services, such as healthcare, transportation, and basic living needs. A lack of financial resources can also limit the ability to purchase essential items, such as assistive devices (e.g. hearing aids and canes). This financial dependency often leads to reliance on family members for support. A 64-year-old woman said, "I need a cane now, but I cannot afford it. I cannot even buy groceries because I do not have enough money. My children are not financially well off either, so they cannot help me buy a cane (participant 31, 64 years old, housewife)".

b. Financial status related to the family of the elderly person: Another important aspect of economic security for older adults is their family members' financial situation. In many cases, older adults depend on their children or spouses for financial support, especially if they are unable to work due to age or health conditions. If a family is financially strained or unable to provide support, it can worsen the QoL of older adults. A 66-year-old woman explained her situation: "My daughter is 30 years old, but we still cannot afford the necessary medical equipment for me. The financial burden on our family is heavy, and I feel like my health and well-being are suffering because of it (participant 22, 66 years old, housewife)."

c. Income sources for the elderly: Sources of income available to the elderly, such as government subsidies, relief funds, and financial support from relatives, play a crucial role in QoL. In some cases, older adults may rely on loans or personal savings. A stable income can significantly improve their ability to access healthcare, nutrition, and social activities, leading to better QoL. A 78-year-old woman shared her thoughts on her financial situation: "I receive a small subsidy from the government each month. It is not enough to cover all my expenses, but without it, I would not be able to survive (participant 24, 78 years old, housewife)."

Access to foundation

Access to a Foundation is a key factor influencing the QoL of older adults. This factor can be divided into two subcategories:

a. Access barriers

b. Access facilitators

a. Access barriers: Some elderly individuals can visit the Foundation regularly, either alone or with assistance. However, for others, physical limitations or other obstacles may prevent frequent visits. A 60-year-old woman said, "I suffer from foot pain and cannot go to the committee myself. Every time the bell rings, my daughter goes to my place and brings whatever is needed for me (participant 26, 60 years old, housewife)".

Other access barriers include transportation problems, financial constraints, feelings of shame, illiteracy, and environmental problems. A 78-year-old woman shared her struggles with accessing Foundation: "I never go to Foundation. I do not have a way to get there on my own. I am afraid to travel by car and do not want to go alone, especially with all the obstacles in the streets (participant 24, 78 years old, housewife)".

b. Access facilitators: Family support and assistance with commuting to the Foundation, as well as visits by social workers, were identified as facilitators of access to the Foundation's services.

Perceived provided services

The services provided by the Foundation are related to QoL. Based on the findings, the perceived services can be categorized into two areas: the perceived adequacy and responsiveness of services. Approximately half of the participants were satisfied with the services provided by the Foundation, while the other half expressed dissatisfaction.

A lack of satisfaction with the services provided by Foundation and the frequency of visits often stems from inadequate assistance, infrequent visits, and unmet expectations from the elderly and their families. A 65-year-old man expressed his frustration: "The money the Foundation gives me is very little every month. With this amount, I cannot do anything. I cannot even buy what I need (participant 28, 65 years old, retired)". Similarly, a 61-year-old woman said, "I asked for a refrigerator, but they keep saying it is not available. Every time I ask, they tell me the same thing: 'Not now.' I still have not received anything (participant 29, 65 years old, housewife)."

The level of satisfaction expressed by relatives often depends on the money or assistance the elderly receive from the Foundation. If support is perceived as inadequate, relatives may also express dissatisfaction with the services provided. A 66-year-old woman said, "The money the Foundation gives is not enough. I understand this, but it is still not enough to meet my needs. Every month, they give me a little money, but it is not enough to buy what I need (participant 18, 66 years old, housewife)." Full satisfaction is achieved when the Foundation's services meet the needs of the elderly and the frequency of visits is sufficient. For the elderly, satisfaction often depends on the availability of assistance and frequency of support provided. A 72-year-old woman expressed her contentment: "Whenever I needed something, I could ask the helpers at the Foundation. They always help me right away. The services are good, and I am satisfied (participant 11, 72 years old, housewife)."

Unmet needs and expectations

Unmet needs and expectations from the Foundation play a crucial role in improving the QoL of older adults. The main areas are as follows:

a. Financial needs

b. Non-financial needs

a. Financial needs: One of the most significant requests made by the elderly is help with medication costs. Many elderly individuals rely heavily on the support provided by Foundation for their healthcare needs. A 60-year-old woman said, "My son and my husband are both sick, and the cost of their medication is overwhelming. I wish the Foundation could help cover their medical expenses and treatment (participant 14, 60 years old, housewife)".

Some elderly individuals also request financial aid for home repairs or assistance with the costs of their children's dowries. A 60-year-old woman expressed her preferences: "I do not need anything for myself, but I would like help with my daughter's dowry. It would also be great if I could get a heater for her (participant 19, 60 years old, housewife)."

In addition to basic necessities, the elderly often request financial assistance for daily needs, including food, and employment opportunities to supplement their income. Some elderly individuals expressed a desire for more work opportunities to improve their financial situations. A 60-year-old woman voiced her concerns: "My husband had been ill for some time, and we did not have enough income to cover our basic needs. If the Foundation could help with financial support, it would be a great relief for us (participant 26, 60 years old, housewife)".

b. Non-financial needs: Elderly people often require equipment and home supplies, such as washing machines, televisions, refrigerators, and furniture. A 78-year-old woman stated, "I do not have a refrigerator, gas stove, or water heater. My room flooded last year, and my carpet was ruined. I do not have the means to replace these items (participant 27, 78 years old, housewife)."

Discussion

The concept of QoL is multidimensional and subjective, varying considerably across individuals and life contexts. It reflects both objective conditions and subjective perceptions of well-being, including physical and mental health. For older adults, QoL is shaped by life-course experiences, accumulated resources, and age-related changes that differentiate this stage of life from younger age groups. Consequently, perceptions of QoL among older adults tend to be highly individualized. Although previous studies have examined QoL across different age groups, many have focused on populations under 60 or relied primarily on standardized quantitative instruments [23]. In contrast, the present study explored how QoL is perceived among older adults who receive institutional support from a governmental welfare organization (Foundation) in Iran. By focusing on this group, this study provides insights into how institutional assistance, financial vulnerability, and social relationships interact to shape the lived experience of aging.

The findings suggest that QoL among older adults is shaped by several interrelated domains, including life satisfaction, physical health, psychological well-being, social relationships, economic security, environmental conditions, and the perceived effectiveness of supportive services. These domains are consistent with established conceptualizations of QoL proposed by Hughes [24, 25] and with the dimensions reflected in widely used measurement instruments, such as the older people's quality of life questionnaire [26], WHOQOL-old module [27], WHOQOL-BREF [28], 36-item short form survey [29], and the later life disability and activity questionnaire [30]. However, beyond confirming these dimensions, the findings highlight how they are experienced within the context of poverty and institutional dependency. In this setting, institutional support does not replace family or social networks but rather interacts with them, sometimes reinforcing support and at other times revealing gaps between formal assistance and everyday needs.

Life satisfaction emerged as a central dimension of QoL among the participants. Rather than being a static indicator, life satisfaction appeared to reflect an ongoing evaluation of personal circumstances, health status, and social relationships. This finding is consistent with previous literature identifying life satisfaction as a key determinant of overall QoL [31]. Older adults who expressed higher life satisfaction often described better physical and psychological well-being, whereas those with lower satisfaction frequently reported health problems, social isolation, or limited support [32]. Life satisfaction has also been widely recognized as an indicator of mental health and an important component of successful aging. Although some studies suggest that life satisfaction may decline with age due to health deterioration and environmental changes, others emphasize the ability of older adults to maintain a positive outlook when social relationships and supportive environments are present [33].

Beyond confirming these patterns, the findings suggest that life satisfaction among elderly individuals receiving institutional support may involve a complex balance between acceptance, gratitude, and unmet expectations. Many older adults appeared to evaluate their lives not only in terms of current conditions but also through reflection on their past achievements, family relationships, and future uncertainties [34]. In this sense, life satisfaction can be understood as a relational concept shaped by the alignment between personal expectations and available resources. For older adults with limited financial means, institutional assistance may provide essential security, yet it may not fully compensate for broader social or emotional needs.

Socioeconomic conditions, particularly financial resources and social networks, play a critical role in shaping life satisfaction [35]. Access to economic and social resources influences health outcomes and well-being through multiple mechanisms, reflecting broader patterns of social inequality. Physical limitations and chronic health conditions can also reduce life satisfaction [34, 36].

Simultaneously, social support—especially from family members and community networks—can buffer the negative effects of financial hardship [9, 37-39]. In Iran's cultural context, where family solidarity and intergenerational support are highly valued, the interaction between family assistance and institutional support becomes particularly important. For some elderly individuals, receiving aid from a support institution may coexist with family support, while for others it may reflect the absence or insufficiency of family resources. These dynamics highlight the complex relationship between poverty, family structures, and institutional welfare systems in shaping QoL among older adults.

Health and life satisfaction

The results highlight the importance of physical, psychological, and social health as key dimensions of QoL in older adults. Consistent with previous research, these dimensions are closely interconnected and collectively influence overall well-being [40, 41]. Physical health conditions, chronic illnesses, and functional limitations often affect independence and daily activities, which in turn shape psychological well-being and social participation. At the same time, psychological resilience and supportive relationships can help older adults cope with physical limitations.

These findings also suggest that health should be understood not only as the absence of disease but as a broader state of functional and social well-being. Previous studies have emphasized that factors, such as independence, perceived control over life, and supportive external conditions—including socioeconomic status and social capital—are important contributors to QoL in old age [40, 41]. In the present study, these factors appeared to interact in complex ways: health limitations often increased reliance on family members or institutional support, while strong social relationships mitigated the negative impact of illness on perceived QoL.

Environmental conditions

The physical environment is another important dimension of QoL in later life. Housing conditions, neighborhood infrastructure, and access to services can significantly influence well-being and independence among older adults. Participants in this study described inadequate housing conditions and limited environmental resources as challenges affecting their daily lives. These findings are consistent with previous studies demonstrating that suitable housing and supportive environments are essential for maintaining QoL in old age [42].

Environmental adaptation is particularly important for elderly individuals experiencing physical limitations. Norazizan et al. (2006) reported that older adults who were able to adapt their living environments to their needs experienced higher levels of QoL and life satisfaction [17, 42]. However, in contexts where financial resources are limited, the ability to modify housing conditions or access supportive environments may be restricted. For elderly individuals receiving institutional assistance, environmental challenges may therefore reinforce dependence on external support services.

Economic security

Economic security emerged as a fundamental factor shaping QoL among the participants. Adequate income enables individuals to maintain access to healthcare, engage in social activities, and preserve a sense of autonomy, whereas financial hardship may lead to dependence on family members or support institutions [43]. Economic vulnerability in old age can influence multiple aspects of life, including health, social participation, and psychological well-being. Previous studies have consistently shown that financial insecurity is associated with reduced QoL among older adults [44-46].

However, the findings of this study also suggest that financial resources alone do not fully determine QoL. Instead, financial status interacts with other factors, such as health conditions, family support, and access to institutional services. In some cases, institutional support can partially mitigate the effects of poverty by providing essential resources, such as pensions, health coverage, and subsidies. At the same time, reliance on institutional assistance may also reflect broader structural inequalities that limit opportunities for economic security in later life [44, 47-50]. Thus, financial support programs play a crucial role in maintaining basic well-being but may not fully address the broader social and emotional needs of older adults.

Access to foundation

Inadequate access to health care facilities, social services, and community support can severely affect the QOL of older adults. The findings of this study also emphasize that many elderly individuals are dissatisfied due to limited access to supportive services. This issue is particularly pronounced in areas where there are barriers, such as the physical inaccessibility of buildings, transportation issues, financial constraints, and lack of literacy, which prevent the elderly from fully benefiting from available services. One of the critical challenges

identified was the physical infrastructure of supportive institutions, such as Foundation. For instance, the presence of stairs and a lack of adequate transportation options often prevent the elderly from accessing the services they need. Institutions must address these barriers to improve the elderly's access to healthcare, counseling, and other vital services [12].

Perceived provided services

Satisfaction with Foundation's services was measured at three levels: no satisfaction, relative satisfaction, and complete satisfaction. Many elderly individuals expressed dissatisfaction with the services provided, particularly due to delays in receiving assistance or feelings that their needs were not adequately addressed. Despite receiving financial support, many elderly individuals still felt disconnected from Foundation's services, highlighting the importance of meeting their needs in a more comprehensive and timely manner. This dissatisfaction is particularly evident in financial assistance programs, where the level of support is often insufficient to cover living expenses or healthcare needs. Additionally, elderly individuals who are less financially stable are often more reliant on institutional support, and any delays or inadequacies in the assistance they receive can significantly affect their QoL [12].

Unmet needs and expectations

Elderly participants also expressed a variety of preferences and needs related to the support they received. The most common requests included assistance with medical costs, home equipment and supplies, and financial support for basic needs, such as food and housing. Many elderly individuals expressed that their primary need was financial assistance to cover medical expenses and the costs of living, particularly because they had limited income and high healthcare costs. This study confirms that the majority of older adults supported by Foundation have similar needs, particularly regarding financial support, medical assistance, and home equipment.

The primary functions of the support institutions highlighted in this study focus on assisting elderly individuals who need financial resources but lack them. This includes offering medical and rehabilitation coverage and providing monthly pensions. As the most comprehensive official support institution in the country, it systematically delivers essential support services to the elderly [49]. For the elderly and impoverished retirees, the institution's support services encompass rehabilitation assistance, subsidies, and access to facilities. These services are extended to individuals and families who are unable to work because of various circumstances or whose income falls below the minimum required for subsistence [50]. In many countries, even when the elderly are not included in insurance programs or pension funds, they are covered by support institutions. These institutions receive the necessary social, welfare, and medical services [10].

Conclusion

This study identified key dimensions shaping the QoL of economically disadvantaged older adults supported by the Foundation in Yazd City, including life satisfaction, health (physical, mental, and social), economic security, environmental conditions, institutional support, services provided by the Foundation, satisfaction with these services, participants' preferences, and needs. While these dimensions are broadly consistent with multidimensional QoL frameworks, the findings highlight how financial vulnerability and reliance on institutional support shape older adults' lived experiences in this context.

Participants emphasized the Foundation's central role not only as a provider of financial assistance but also as an important source of social and institutional support. However, their accounts also revealed unmet needs related to financial stability, access to healthcare services, social interaction, and responsiveness of support programs. These findings suggest that improving QoL among economically disadvantaged older adults requires integrated welfare and health policies that combine financial assistance with accessible healthcare services, opportunities for social engagement, and more responsive support programs.

From a policy and service perspective, the findings underline the importance of strengthening coordination between welfare institutions and healthcare systems to better address the multidimensional needs of vulnerable older adults. Targeted transportation support, home improvements, prioritization of drug subsidies, and provision of psychosocial support programs can be considered as operational and policy implications. Finally, future studies could build on these findings by employing mixed-methods designs or intervention-based research to evaluate strategies to improve health, social participation, and service accessibility among institution-supported elderly populations.

Limitations

This study had several limitations, including a sample drawn from only one city, Yazd, which may not fully represent the diverse experiences of elderly individuals in other regions. Additionally, the sample was skewed toward a higher proportion of women, which may have influenced the findings. Other limitations of this study were the possible social desirability bias in interviews with Foundation-linked participants, absence of caregiver or staff perspectives, and potential constraints on transferability to non-beneficiaries or wealthier elderly. Finally, challenges in interviewing clients, such as lack of cooperation from some elderly participants, also impacted the data collection process.

Ethical Considerations

Compliance with ethical guidelines

This study was approved by the Research Ethics Committee of Shahid Sadoughi University of Medical Sciences, Yazd, Iran (Code: IR.SSU.SPH.REC.1402.138). Before the study commenced, its purpose was explained to the participants, and written or oral consent was obtained. Participants were assured of the confidentiality of their information and the protection of their privacy.

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Authors contributions

Resources, data collection and analysis: Razieh Sadeghi and Hassan Rezaeipandari; Writing: Razieh Sadeghi and Hassan Rezaeipandari; Conceptualization, study design, and final approval: All authors.

Conflict of interest

The authors declared no conflict of interest.

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